Central Maine Orthopaedics, P.A.

OFFICE VISIT JAMES M. TIMONEY, D.O.

KASSIDY BORTNER
D.O.B.: 02/04/99
DATE OF SERVICE: 9/11/00

HISTORY: Patient is a 19-month-old who is seen for evaluation of an in-toed gait. She is the product of a normal vaginal delivery. I don't have a good history on the father. The mother says there is no history of any family incidence of in-toed gait or hip dysplasias. She has had normal milestones since delivery. She was walking at 8 months.

PHYSICAL EXAMINATION: She is a little unhappy today. It is right about nap time, so she is a little bit cranky. It was difficult to get her to walk naturally. I appreciate about an 18 degree internal rotation deformity of the right. The left seems a little bit less at about 15 degrees perhaps. Her leg lengths are equivalent. Her abduction is excellent at about 45 degrees. When measured with the patient prone, external rotation is excellent at about 70 degrees. Internal rotation is similarly excellent at about 75 degrees. When the child is running there seems to be significantly less internal rotation, back almost to neutral. Estimation of her femoral anteversion is actually a little bit high, it seems to be about 30 degrees bilaterally. Interestingly, she seems to hold the right foot in a slightly adducted position, although when you get her to relax, she actually appears to have a neutral foot.

PLAN: She will followup in one year for a check. I think this will resolve to some degree over time, although I suspect she will have some residual deformity. I reassured them that this should resolve on its own to some degree and no active intervention is required.

James M. Timoney, D.O.

JMT/bjb
Dictated, not proofread

pc: Dr. Glass

Patient Medical Information Sheet

Name: Kassidy Bartner Today's Date: 9-11-00
Date of Birth: 2/4/99

Past Medical History: Please check any conditions you have or have had in the past:

- ☐ AIDS/HIV positive
- ☐ Appendicitis
- ☐ Blood clots
- ☐ Emphysema
- ☐ Gonorrhea
- ☐ High blood pressure
- ☐ Prostate problems
- ☐ Stroke
- ☐ Alcoholism
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy/seizures
- ☐ Gout
- ☐ Kidney disease
- ☐ Psychiatric care
- ☐ Thyroid problems
- ☐ Anemia
- ☐ Asthma
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Liver disease/hepatitis
- ☐ Rheumatic fever
- ☐ Tuberculosis (Tb)
- ☐ Anorexia
- ☐ Bleeding disorders
- ☐ Drug dependency
- ☐ Goiter
- ☐ High cholesterol
- ☐ Migraines
- ☐ Stomach ulcers

Comments: _____

Past Surgical History: Please list all surgeries/hospitalizations you have had, and the approximate year

Surgery or reason for hospitalization	Year

Medications: Please list all of the medications (with dosages if possible) you are taking. Include over-the-counter medications as well.

Allergies: Are you allergic to any medications/substances?

☒ no ☐ yes; if yes, please list: _____

→→TURN OVER PLEASE →→

Social History:

Do you smoke or chew tobacco? ☑ no ☐ yes: _____ packs per day for _____ years
Did you ever smoke or chew tobacco? ~~☒ no~~ ☐ yes: When did you quit? _____
Alcohol intake: ~~☒ never~~ ☐ rare ☐ occasional, Average number of drinks per day: _____
Do you currently or have you used recreational drugs? ☐ yes ~~☒ no~~
Occupation (current or previous): _____
Are you working: ☐ full-time ☐ part-time ☐ retired ☐ disabled

Family History: Have your relatives had any of the following medical problems? Place a check under the appropriate columns:

	Unknown	Healthy	Arthritis	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Lung Disease	Stroke
Mother		✓							
Father		✓							
Brother (s)									
Sister (s)									
Children									
Aunts/Uncles		✓							
Grandparents		✓							

Review of Systems: Please check any problems you currently have or have had in the past:

☐ Fatigue	☐ Fever	☐ Weight change	☐ Blurred or double vision
☐ Glaucoma	☐ Cataracts	☐ Macular degeneration	☐ Bleeding gums
☐ Earaches	☐ Hearing loss	☐ Ringing in ears	☐ Mouth sores
☐ Nose bleeds	☐ Sinus trouble	☐ Voice change	☐ Chest pain
☐ Poor circulation	☐ Rapid heart beat	☐ Irregular heart beat	☐ High blood pressure
☐ Swelling of ankles	☐ Shortness of breath with walking		☐ Calf pain with walking
☐ Chronic cough	☐ Coughing up blood	☐ Shortness of breath	☐ Wheezing
☐ Blood in urine	☐ Frequent urination	☐ Lack of bladder control	☐ Frequent urination at night
☐ Painful urination	☐ Poor appetite	☐ Constipation	☐ Diarrhea
☐ Indigestion	☐ Hemmorhoids	☐ Heartburn	☐ Nausea/vomiting
☐ Rectal bleeding	☐ Easy bruising	☐ Change in moles	☐ Sore that won't heal
☐ Rash	☐ Hives	☐ Convulsions/Seizures	☐ Frequent headaches
☐ Head injury	☐ Light headed	☐ Numbness in arms/legs	☐ Dizziness
☐ Paralysis	☐ Tremors	☐ Depression	☐ Insomnia
☐ Nervousness	☐ Memory loss	☐ Confusion	☐ Excessive thirst/urination
☐ Heat intolerance	☐ Cold intolerance	☐ Easy bruising/bleeding	☐ Enlarged glands/lymph nodes
☐ Phlebitis	☐ Slow to heal	☐ None of the above	
For women only:	☐ Breast lump	☐ Bleeding between periods	☐ Abnormal pap smear

Date of last menstrual period: _____ Date of last pap smear: _____
Date of last mammogram: _____
Pain, stiffness, swelling in: ☐ Arms ☐ Back ☐ Neck ☐ Feet ☐ Hands
☐ Hips ☐ Legs ☐ Shoulders
Comments: _____

Reviewed by: _____ Date: _____

PATIENT INFORMATION SHEET

PATIENT'S NAME (PLEASE PRINT) FIRST MIDDLE INITIAL LAST	S S NUMBER (PATIENT)	SEX	MARITAL STATUS	BIRTH DATE
Cassidy C Bortner		M (F)	M (S) W D	2/4/99 AGE 19m

STREET ADDRESS	CITY & STATE	ZIP CODE	HOME PHONE #
15 Hatchard	Auburn	04210	782-1893
MAILING ADDRESS	CITY & STATE	ZIP CODE	DAY PHONE #
same			same

EMPLOYER	EMPLOYER'S ADDRESS:	PHONE #:
not right now		

NAME OF SCHOOL (IF STUDENT)	DESCRIPTION OF ACCIDENT/ILLNESS:

DATE OF INJURY:	WERE YOU INJURED DURING SCHOOL ACTIVITY	WERE YOU INJURED ON THE JOB	WAS THIS AN AUTO ACCIDENT
-- --	___YES ___NO	___YES ___NO	___YES ___NO

REFERRED BY:	ALLERGIES:	PLEASE CIRCLE (IF APPLICABLE):
Pediatric Associates		UNEMPLOYED RETIRED DISABLED

PRIMARY CARE DOCTOR: FIRST LAST	ADDRESS:	PHONE #

IN CASE OF EMERGENCY CONTACT NAME: Amanda PHONE #: 207-782-1893 RELATIONSHIP: mom
ADDRESS: [redacted] Bortner

HAVE YOU HAD X-RAYS FOR THIS PROBLEM: ___YES /NO WHEN: WHERE:

PERSON RESPONSIBLE FOR PAYMENT:	MAILING ADDRESS:	S. S. NUMBER: HOME PHONE #

NAME OF (PRIMARY) INSURANCE COMPANY	NAME OF INSURED:	DATE OF BIRTH:	POLICY OR CERTIFICATE # GROUP #
medicaid			

INSURED'S EMPLOYER:	EMPLOYER'S ADDRESS:	OCCUPATION: BUS. PHONE #

NAME OF (SECONDARY) INSURANCE COMPANY	NAME OF INSURED:	DATE OF BIRTH:	POLICY OR CERTIFICATE # GROUP #

INSURED'S EMPLOYER:	EMPLOYER'S ADDRESS:	OCCUPATION: BUS. PHONE #

INSURANCE/MEDICAL RECORDS AUTHORIZATION AND ASSIGNMENT

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IN MEDICARE/OTHER INSURANCE COMPANY ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE/OTHER INSURANCE COMPANY AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NONCOVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE/OTHER INSURANCE COMPANY.

I HEREBY AUTHORIZE CENTRAL MAINE ORTHOPAEDICS, P.A. TO RELEASE MEDICAL INFORMATION TO PHYSICIANS AND OTHERS RESPONSIBLE FOR MY CARE AND TO THIRD PARTIES PAYING FOR MY CARE. I HEREBY CONSENT TO MEDICAL TREATMENT BY CENTRAL MAINE ORTHOPAEDICS, P.A.

I UNDERSTAND THAT EVEN THOUGH I MAY OR MAY NOT HAVE SOME TYPE OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR PAYMENT OF SERVICES. I UNDERSTAND THAT ANY COST, INCLUDING ATTORNEY'S FEES, INCURRED IN THE COLLECTION OF THIS ACCOUNT WILL BECOME MY RESPONSIBILITY.

DATE: 9/11/00 SIGNATURE: X Amanda Bortner

Amanda (mom)

New Patient Information

Date: 8/17/00

Name: Kassidy Bortner Date of Birth: 2/4/99

Mailing Address: 15 Hatch Rd aub

Home Phone: 782-1893 Work Phone: _____

Gender: M (F) CMO History? Y N MD: _____

Date of Injury: Since Birth

Type of Injury: toeing in

How injured: _____

Sports Related: YES NO School currently attending _____

How treated: _____

Who Referred You? Jeorce 6/00 PCP: _____ Referral: (YES) NO

Were you injured on the job? _____

Insurance: (YES) NO Rumacre

Were you seen in the emergency room: YES (NO)

What emergency room: _____

Have you had X-rays (Arthrogram, Bone Scan, EMG, MRI, Plain films) taken for this problem: Y (N)

Where: _____

When: _____

Patient asked to bring films: YES NO Other arrangements: _____

Have you seen another physician for this problem: YES NO

Physician seen: _____. Records to be obtained: YES NO

Intake taken by: Rmg Time: 2:10

Appointment date and time: 9/11 @ 3:00 CMO Doctor: JMT

~~Pt. Aware~~ ~~In Computer~~ Initials: Rmg

Physician Dx _____

Cc: X-ray ☐ Switchboard ☐

State Of Maine
Department of Human Services

Medical Eligibility Card

20 0 020010
AMANDA J BORTNER
15 HATCH RD

AUBURN ME 04210

Use this card to get Medicaid or Cub Care services.
You may use this card in Maine, in New Hampshire within 15 miles of the Maine border, in Canada within 5 miles of the Maine border. You may use this card anywhere in case of an emergency (accident or illness). Be sure to ask if the health care provider accepts Maine Medicaid/Cub Care to pay for services provided. If the provider doesn't, you will have to pay for the services.

Medicaid/Cub Care Card For: SEP 2000

CO-PAY	ELIGIBLE CLIENT NAME	ID NUMBER	BIRTHDATE	INSURANCE
NO	AMANDA J BORTNER	[redacted]	[redacted]	
NO	KASSIDY BORTNER	[redacted]	02/04/99	

Note: If the co-pay column is blank, you must pay a co-payment for certain Medicaid /Cub Care covered services.

TO OUT OF STATE PROVIDERS: Do not honor this card unless you have received Prior Authorization from Maine Medicaid/Cub Care except (1) in case of an emergency (accident or illness) or (2) within 15 miles of the Maine/New Hampshire border or 5 miles of the Maine/Canada border. See above. Send claims to the Provider File Unit, Bureau of Medical Services, 11 State House Station, Augusta, Maine 04333-0011.

MMIS2A 5/00